Westcoast SpineCenter

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Authorization For Treatment And Consent For Care

I hereby voluntarily consent to Chiropractic Care provided by WestCoast Spine Center, its physicians and employees as explained to me by the Attending Physician and whomever he/she may designate as his/her assistant. I am aware that the practice of medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees can be made to me as a result of any treatment or examination in the office.

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an Insurance carrier and myself; however, WestCoast Spine Center may accept certain insurance assignments of benefits. The acceptance of Insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable.

Patient Signature____Date__________________________________

Relationship, if Guardian____

ALL FEMALE PATIENTS - PLEASE COMPLETE THIS SECTION

In order to protect you, the patient, we need to be assured that if the Doctor orders x-rays, there is no possibility of pregnancy.

I hereby release you and your staff from any responsibility for injury or complications to my fetus or myself should I be pregnant on this date.

_____ There is a possibility of me being pregnant

_____ There is NO possibility of me being pregnant

Signature of Patient_______________________________________Date________________________________

Relationship, if Guardian____